



# Cardio Policy:

## Coronary Intra Vascular Arterial Ultrasound

<b>POLICY NUMBER</b> UM CARDIO_1292	<b>SUBJECT</b> Coronary Intra Vascular Arterial Ultrasound	<b>DEPT/PROGRAM</b> UM Dept	<b>PAGE 1 OF 3</b>
<b>DATES COMMITTEE REVIEWED</b> 05/24/16, 12/21/16, 10/11/17, 11/14/18, 03/13/19, 12/11/19, 06/10/20, 06/14/21, 11/09/21, 07/13/22	<b>APPROVAL DATE</b> July 13, 2022	<b>EFFECTIVE DATE</b> July 29, 2022	<b>COMMITTEE APPROVAL DATES</b> 05/24/16, 12/21/16, 10/11/17, 11/14/18, 03/13/19, 12/11/19, 06/10/20, 06/14/21, 11/09/21, 07/13/22
<b>PRIMARY BUSINESS OWNER:</b> UM		<b>COMMITTEE/BOARD APPROVAL</b> Utilization Management Committee	
<b>URAC STANDARDS</b> HUM v8: UM 1-2; UM 2-1	<b>NCQA STANDARDS</b> UM 2	<b>ADDITIONAL AREAS OF IMPACT</b>	
<b>CMS REQUIREMENTS</b>	<b>STATE/FEDERAL REQUIREMENTS</b>	<b>APPLICABLE LINES OF BUSINESS</b> Commercial, Exchange, Medicaid	

### I. PURPOSE

Indications for determining medical necessity for Coronary Intra Vascular Arterial Ultrasound (IVUS).

### II. DEFINITIONS

IVUS is a specially designed catheter with a miniaturized ultrasound probe attached to the distal end of the catheter. IVUS when introduced in a coronary artery during cardiac catheterization, provides more precise information about the severity of stenosis and plaque morphology than does coronary angiography such as for the lumen of ostial lesions or where angiographic images do not visualize lumen segments adequately, such as regions with multiple overlapping arterial segments. It is also used to assess the effects of treatments of stenosis such as with hydraulic angioplasty expansion of the artery, with or without stents, and the results of medical therapy over time.

Appropriate Use Criteria (AUC score) for a service is one in which the expected incremental information, combined with clinical judgment, exceeds the expected negative consequences by a sufficiently wide margin for a specific indication that the procedure is generally considered acceptable care and a reasonable approach for the indication. The ultimate objective of AUC is to improve patient care and health outcomes in a cost-effective manner but is not intended to ignore ambiguity and nuance intrinsic to clinical decision making.

Appropriate Care- Median Score 7-9

May be Appropriate Care- Median Score 4-6

Rarely Appropriate Care- Median Score 1-3

### III. POLICY

**Surgical procedures are reviewed and approved by Physicians and Nurses only. Utilization Management staff (pharmacists, intake coordinators or any other type of lower level medical staff) cannot review or approve surgical procedures within New Century Health.**

**Indications for approving a request for medical necessity are:**

- A. IVUS is reasonable for the assessment of angiographically indeterminant left main CAD. **(AUC Score 5)<sup>1,2,3,4</sup>**
- B. IVUS and coronary angiography are reasonable 4 to 6 weeks and 1 year after cardiac transplantation to exclude donor CAD, detect rapidly progressive cardiac allograft vasculopathy, and provide prognostic information. **(AUC Score 5)<sup>1,2,3,4</sup>**
- C. IVUS is reasonable to determine the mechanism of stent restenosis and stent thrombosis. **(AUC Score 5)<sup>1,2,3,4</sup>**
- D. IVUS may be reasonable for the assessment of non-left main coronary arteries with angiographically intermediate coronary stenosis (50% to 70% diameter stenosis). **(AUC Score 5)<sup>1,2,3,4</sup>**
- E. IVUS may be considered for guidance of coronary stent implantation, particularly in cases of left main coronary artery stenting. **(AUC Score 5)<sup>1,2,3,4</sup>**

**Limitations:**

- A. IVUS for routine lesion assessment is not recommended when revascularization with PCI or CABG is not being contemplated.
- B. Requests for services that are part of a surveillance protocol for patients who are involved in a clinical trial are considered out of scope (OOS) for New Century Health and cannot be reviewed.

### IV. PROCEDURE

- A. In order to review a request for medical necessity, the following items must be submitted for review:
  - 1. Progress note that prompted request
  - 2. Prior Diagnostic coronary angiogram
  - 3. Non-invasive vascular testing
- B. Primary codes appropriate for this service: IVUS-92978, 92979

### V. APPROVAL AUTHORITY

- A. Review – Utilization Management Department
- B. Final Approval – Utilization Management Committee

### VI. ATTACHMENTS

- A. None

## VII. REFERENCES

1. Amir Lotfi, MD, et al. Expert Consensus Statement on the Use of Fractional Flow Reserve, Intravascular Ultrasound, and Optical Coherence Tomography: A Consensus Statement of the Society of Cardiovascular Angiography and Interventions. Catheterization and Cardiovascular Interventions. Oct 2013. Volume 83, Page 509-518
2. Levine GN, et al. 2011 ACCF/AHA/SCAI Guideline for Percutaneous Coronary Intervention. A report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines and the Society for Cardiovascular Angiography and Interventions. Journal of the American College of Cardiology. Volume 58, Issue 24, Pages e44-122.
3. Pijls NH, et al. Percutaneous coronary intervention of functionally nonsignificant stenosis: 5-year follow-up of the DEFER Study. Journal of the American College of Cardiology. May 2007. Volume 49, Issue 21, Pages 2105–11.
4. Robert C. Hendel MD, FACC, FAHA, et al. Appropriate use of cardiovascular technology: 2013 ACCF appropriate use criteria methodology update: a report of the American College of Cardiology Foundation appropriate use criteria task force. Journal of the American College of Cardiology. March 2013, Volume 61, Issue 12, Pages 1305-1317.
5. NCQA UM 2022 Standards and Elements.